Printed: 07/27/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		175537		B. WING		07/27	7/2015
	OVIDER OR SUPPLIER  DICAL CENTER LTCU		STREET ADDRE  2220 SW  HAYS, KS	CANTERB	TE, ZIP CODE  URY DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
	The following citations represent the findings of a Health Resurvey.  483 25(I) DRUG REGIMEN IS ERFE FROM		s of a				
F 329 SS=E				F 329			
	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		s any d or quate ose				
	This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents who were reviewed for unnecessary medications. Based on observation, record review and interview, the		wed				
LABORATOR	facility failed to ensure resident's drug regime unnecessary drug use DIRECTOR'S OR PROVIDER	en were free from e. (#56, #57, #10, #55)	F'S SIGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		175537		B. WING		07/2	7/2015
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
HAYS ME	DICAL CENTER LTCU			W CANTERB KS 67601	SURY DRIVE		
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F 329	Continued From page	e 1		F 329			
	Findings included:						
	assessment, dated 7/had intact cognition, r of 1 staff with bed mo corridor, dressing, toil personal hygiene. The resident had an unstead wheelchair, receimedication, insulin injudications.  The 7/15/15 care plar monitor the medication resident for adverse owith the administration box warnings.  The 7/14/15 physician to administer to the remedications. Further	ons for side effects. The for monitoring of the consequences associate n of medications with ben's orders directed the sesident, the following review revealed the	sident nce in with the alker pain care ed lack				
	physician ordered medications had (BBW) Black Box Warnings:  1) Metformin Hydrochloride (a diabetes						
	medication), 1000 (m daily, initiated 7/13/15	g) milligrams, orally, tw 5.	ice				
	black box warning wa acidosis (low pH in bo is a rare, but serious,	Vatch, dated 8/27/2008,	which that				

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F 329	. 0			F 329		
	2) Lopressor (a blood pressure medication), 75 mg, orally, once daily, initiated 7/13/15.					
	According to the FDA, MedWatch, dated 12/21/12, a black box warning was identified for ischemic heart disease (reduced blood supply to the heart).					
	3) Oxycodone Hydrochloride(a narcotic pain medication), 5-10 mg, orally, every 4 hours, (PRN) as needed, initiated 7/13/15.					
	According to the FDA, MedWatch, dated 1/8/10, a black box warning was identified for respiratory depression.					
	4) Tylenol (acetamino every 4 hours, PRN, i	ophen), 325-650 mg, or initiated 7/13/15.	ally,			
	a black box warning we potential for severe livallergic reactions (swetthroat, difficulty breath added to the label of products that contain patients not to exceed	ver injury and a potentia elling of the face, mouth hing, itching or rash) wi all prescription drug acetaminophenAdvis	al for h and ill be			
	On 7/22/15 at 8:15 AM, observation revealed Resident #56, seated on the edge of his/her bed, and staff administering morning medications to him/her.		bed,			
	verified the resident d	M, Administrative Nurse lid not have an individu the staff to monitor for				

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLET			
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F 329	. 3			F 329					
	adverse consequences associated with the administration of BBW medications.  Administrative Nurse A stated the facility does not have a system for care planning of BBW medications.  Although requested, the facility did not provide a policy for the care planning of the BBW medications.  The facility failed to identify and monitor Resident								
	#56 for the adverse of with the potential adm medications with blace	acility failed to identify and monitor Resident or the adverse consequences associated ne potential administration of these ations with black box warnings.  facility admitted Resident #57 on 7/20/15,							
	and indicated the resi required assistance w upper extremity streng	dent was alert and orie vith ambulation, normal	nted,						
	monitoring of the resid	ated with the administr							
	The 7/21/15 physician's orders directed the staff to administer to the resident, the following medications. Further review revealed the physician ordered medications had (BBW) Black Box Warnings:								
	1) Lopressor (a blood pressure medication), 25 mg, orally, twice daily, initiated 7/20/15.		25						
	According to the FDA 12/21/12, a black box	, MedWatch, dated warning was identified	for						

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F 329	Continued From page	e 4		F 329					
	ischemic heart disease (reduced blood supply to the heart).		ly to						
	2) Acetaminophen, 650 mg, every 4 hours, (PRN), as needed, initiated 7/14/15.								
	According to the FDA, MedWatch, dated 1/13/11, a black box warning was identified for the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophenAdvise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams.								
	Resident #57, lying in	M, observation revealed his/her bed, and staff g medications to him/he							
	On 7/22/15 at 2:58 PM, Administrative Nurse A verified the resident did not have an individualized care plan instructing the staff to monitor for adverse consequences associated with the administration of BBW medications.  Administrative Nurse A stated the facility does not have a system for care planning of BBW medications.  Although requested, the facility did not provide a policy for the care planning of the BBW medications.		alized						
			de a						
	The facility failed to identify and monitor Resident #57 for the adverse consequences associated with the potential administration of these medications with black box warnings.								
	- Resident #10's 5 Da	ay (MDS) Minimum Dat	a Set						

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F 329	assessment, dated 7/had intact cognition, rassistance of 1 staff vof Daily Living, and hat The MDS further indicanticoagulant (blood antipsychotic (medicamedications.  The 7/13/15 Psychotr Area Assessment state an antipsychotic medianxiety, and he/shes night.  The 7/13/15 care plar monitoring of the resiconsequences associof medications with both The 7/6/15 physician administer to the resicmedications. Further physician ordered medications. Further physician ordered medications with both administer to the residmedications ordered medications. Further physician ordered medications with box warnings:  *Lovenox (blood thinning to www.fda Lovenox (blood thinning to www.fda Lovenox (blood thinning to spinal (collection of blood traskin or in an organ), volong-term or permaner	r13/15, indicated the restrequired extensive with most (ADLs) Activition and an unsteady balance cated the resident receipthinning medication) and the street of the test mental illnes are provided as a complete of the street o	ties e. ved d ess) are ved of the diff for ation aff to lack g) /15. ov>, black the	F 329			

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F 329	According to www.fda.gov <a href="http://www.fda.gov">http://www.fda.gov"&gt;http://www.fda.gov&lt;&gt;, Risperdal (antipsychotic medication) had a black box warning of increased mortality in elderly patients with dementia-related psychosis.  *Tylenol (non-narcotic pain relief medication)</a>		lack	F 329					
	1000 mg, by mouth, every 6 hours, as needed for pain, initiated 7/4/15 and Norco (narcotic pain relief medication) 1 tablet, 5/325/ mg, by mouth, as needed for pain, initiated 7/10/15.								
	According to the www.fda.gov <a href="http://www.fda.gov">http://www.fda.gov</a> , Tylenol and Norco had a black box warning that identified the potential for severe liver injury and a potential for allergic reactions (swelling of the face, mouth and throat, difficulty breathing, itching or rash).		l for						
	The 7/6/15 physician' appropriate diagnosis anti-psychotic medica		ın						
	On 7/22/15 at 8:25 AM, observation revealed Resident #10, seated upright in his/her recliner, covered with a blanket, with the bedside table and a full container of water in front of him/her.		ner,						
	On 7/22/15 at 5:10 PM, Administrative Nurse A verified black box warnings should be listed on the care plans and the facility does not have a system for care planning of BBW medications. He/she stated the physician discontinued the administration of the anti-psychotic medication to the resident.		on a s.						
		the facility did not provious and and	de a						

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F 329	Continued From page antipsychotic medications with the potential adm medications with blace ensure an appropriate antipsychotic medication. Resident #55's 5 Da assessment, dated 7/had intact cognition, rof 1 staff with most (A Living, and had an unfurther indicated their anticoagulant medications with blace on the resident with the residence of medications with blace of the residence of the residence of medications. Further physician ordered medications. Further physician ordered medications with the residence of the residence	lentify and monitor Resonsequences associated inistration of these is box warnings and to ediagnosis for the usection.  All (MDS) Minimum Data 11/15, indicated the resequired limited assistant ADLs) Activities of Daily isteady balance. The Mesident received tions.  All lacked direction to standent for adverse lated with the administrated with the administrated box warnings.  All sorders directed the sestions had (BBW) Burning medication), 15 (mour of sleep, initiated of the control of the second and Drug	of an ta Set sident nce IDS  Iff for ation staff lack	F 329		PPROPRIATE	
	*Tylenol (acetaminophours (PRN) as need	hen), 650 mg, orally, eved, initiated 7/12/15.	very 4				

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	According to the FDA a black box warning was potential for severe livallergic reactions (swithroat, difficulty breath added to the label of products that contain patients not to exceed maximum total daily of milligrams.  On 7/22/15 at 8:23 Al Resident #55, seated eating breakfast indepoint of the care plans and the system for care plans.  Although requested, the policy for the care plans and the system for care plans.  The facility failed to in the fail the failed to in the fai	A, MedWatch, dated 1/1 was identified for the ver injury and a potentia elling of the face, mouth hing, itching or rash) wi all prescription drug acetaminophenAdvis d the acetaminophen dose (4 grams/day) = 40  M, observation revealed I upright in his/her bed, pendently.  M, Administrative Nurse rnings should be listed of e facility does not have hing of BBW medication the facility did not provid anning of the BBW  dentify and monitor Res consequences associate inistration of these ex box warnings.  A AND PNEUMOCOCO elop policies and proceo influenza immunization resident's legal es education regarding I side effects of the	al for h and lll be se se se soon a ss. de a contact and se de con	F 329					
	medications.  The facility failed to ic #55 for the adverse c with the potential adm medications with black 483.25(n) INFLUENZ IMMUNIZATIONS  The facility must devet that ensure that (i) Before offering the each resident, or the representative receive benefits and potential	dentify and monitor Resionsequences associated ininistration of these city box warnings.  AAND PNEUMOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOCOC	CAL dures	F 334					

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NAME OF PROVIDER OR SUPPLIER  HAYS MEDICAL CENTER LTCU  (XA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)  F 334 Continued From page 9 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization or refusal.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		l l	LE CONSTRUCTION	(X3) DATE SU COMPLE			
HAYS MEDICAL CENTER LTCU  2220 SW CANTERBURY DRIVE HAYS, KS 67601   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG  OR LSC IDENTIFYING INFORMATION)  F 334  Continued From page 9 annually, unless the immunization is medically contraindicated or the resident has already been immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:  (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization due to medical			175537		B. WING		07/	27/2015		
HAYS, KS 67601    (X4)   ID   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   FAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION DATE	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 334  Continued From page 9	HAYS ME	DICAL CENTER LTCU	ı			BURY DRIVE				
annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical	PRÉFIX	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REG	GULATORY	PREFIX	(EACH CORRECTIVE ACTURE CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION		
The facility must develop policies and procedures that ensure that  (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;  (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;  (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and  (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:  (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and  (B) That the resident effects of the immunization; and  (B) That the resident either received the	F 334	annually, unless the incontraindicated or the immunized during this (iii) The resident or the representative has the immunization; and (iv) The resident's medocumentation that infollowing:  (A) That the resident representative was puthe benefits and pote immunization; and  (B) That the resident influenza immunization; and  (B) That the resident influenza immunization on the facility must devet that ensure that  (i) Before offering the immunization, each relegal representative relegal representative relegal representative relegal representative immunization;  (ii) Each resident is of immunization, unless medically contraindical ready been immunicated, iii) The resident or the representative has the immunization; and  (iv) The resident's medicumentation that infollowing:  (A) That the resident representative was puthe benefits and pote pneumococcal immunication.	immunization is medical e resident has already be stime period; he resident's legal he opportunity to refuse edical record includes andicates, at a minimum, at or resident's legal rovided education regarential side effects of influent either received the control of the contro	the rding Jenza dures surding	F 334					

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	Continued From page 10 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.		F 334				
	This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents. Based on interview and record review, the facility failed to develop and implement policies and procedures related to influenza and pneumococcal immunizations.  Findings included:						
	- The facility's admission agreement, listed a standardized statement regarding provided treatments. The agreement lacked specific information for administration of the flu and pneumococcal immunization.  On 7/22/15 at 4:35 PM, Nurse A verified the facility did not develop or implement policies and						
	The facility did not profor the influenza and immunizations.  The facility failed to define the influence and immunizations.	munization of the residence of the process of the p	ents. edure				

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F 428	1 3			F 428			
F 428 SS=E	IRREGULAR, ACT ON			F 428			
		each resident must be ee a month by a license	d				
	The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This Requirement is not met as evidenced by: The facility had a census of 4 residents. The sample included 4 residents who were reviewed for unnecessary medications. Based on observation, record review and interview, the facility's consultant pharmacist failed to report to the director of nursing or the physician, the lack of monitoring of medications with Black Box Warnings for 4 of the sample residents. (#56, #57, #10, #55)						
	Findings included:						
	- Resident #56's 5 da assessment, dated 7, had intact cognition, of 1 staff with bed mo corridor, dressing, toi personal hygiene. The resident had an unstead wheelchair, receimedication, insulin in medications.	sident nce in with d the valker					
	The 7/15/15 care plan	n directed the staff to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175537 B. WING 07/27/2015		27/2015			
NAME OF PROVIDER OR SUPPLIER  HAYS MEDICAL CENTER LTCU			2220 S\	RESS, CITY, STA N CANTERB KS 67601			
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F 428	monitor the medication plan lacked direction resident for adverse of with the administration box warnings.  The 7/14/15 physician to administer to the remedications. Further physician ordered medications. Further physician ordered medication), 1000 (midaily, initiated 7/13/15).  According to the (FD/Administration, Med/Viblack box warning water acidosis (low pH in both is a rare, but serious, can occur due to Mettreatment.  2) Lopressor (a blooding, orally, once daily according to the FDA 12/21/12, a black box ischemic heart disease the heart).  3) Oxycodone Hydroding (PRN) as needed, initial According to the FDA black box warning water depression.	ons for side effects. The to staff for monitoring of consequences associated in of medications with bin's orders directed the sesident, the following review revealed the edications had (BBW) Bin b	f the ed lack staff lack staff lack fice a which that ring 75 for ly to 710, a pry	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
175537 B. WING		07/2	7/2015					
NAME OF PROV	/IDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
HAYS MEDICAL CENTER LTCU				V CANTERB (S 67601	URY DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
e A a p a tra p p m m R d re m W CR a h C v n m T re tra B - a re u m	a black box warning we potential for severe liver allergic reactions (sweethroat, difficulty breath added to the label of a products that contain patients not to exceed maximum total daily dimilligrams.  Review of the consult dated 7/14/15, of Resident 4/15, of Re	nitiated 7/13/15. , MedWatch, dated 1/1 vas identified for the ver injury and a potentia elling of the face, mouth ning, itching or rash) wi all prescription drug acetaminophenAdvis d the acetaminophen lose (4 grams/day) = 40 ant pharmacist review, ident #56's medications datation of the lack of ions with Black Box  M, observation revealed on the edge of his/her g morning medications M, Administrative Nurse onsultant pharmacist his k of monitoring of k Box Warnings.  nt pharmacist failed to of nursing or the physic of medications with Bla sident #56.  d Resident #57 on 7/20 dent was alert and orie with ambulation, normal gth, lower extremities w	al for n and ll be lee looo libed, to lee A ad lian, ack lian, ack lian, with	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175537		B. WING		07/2	27/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HAYS MEDICAL CENTER LTCU				N CANTERB KS 67601	SURY DRIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETION DATE
F 428	of medications with bit The 7/21/15 physician to administer to the remedications. Further physician ordered medications. Further physician ordered medications with physician ordered physician ordered medications. Further physician ordered physician ordere	dent for adverse lated with the administrated with the administrated box warnings.  In's orders directed the sesident, the following review revealed the edications had (BBW) But pressure medication), in initiated 7/20/15.  MedWatch, dated a warning was identified be (reduced blood suppose (reduced	staff lack 25  for ly to  3/11, al for n and ll be se 0000	F 428			
	Resident #57, lying in	his/her bed, and staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175537		B. WING		07/2	7/2015
NAME OF PR	NAME OF PROVIDER OR SUPPLIER  HAYS MEDICAL CENTER LTCU			RESS, CITY, STA	TE, ZIP CODE		
HAYS ME	DICAL CENTER LTCU			V CANTERB (S 67601	URY DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	Continued From page 15			F 428			
	administering morning	g medications to him/he	er.				
	verified the facility's c not addressed the lac medications with Blac The facility's consulta report to the director of	ck Box Warnings.  In pharmacist failed to of nursing or the physic of medications with Black.	ian,				
	- Resident #10's 5 Day (MDS) Minimum Data Set assessment, dated 7/13/15, indicated the resident had intact cognition, required extensive assistance of 1 staff with most (ADLs) Activities of Daily Living, and had an unsteady balance. The MDS further indicated the resident received anticoagulant (blood thinning medication) and antipsychotic (medication to treat mental illness) medications.		sident ties e. ved d				
	The 7/13/15 Psychotropic drug use (CAA) Care Area Assessment stated Resident #10 received an antipsychotic medication each night for anxiety, and he/she stayed awake a portion of the night.		ved				
	The 7/13/15 care plan lacked direction to staff for monitoring of the resident for adverse consequences associated with the administration of medications with black box warnings.						
	administer to the residued medications. Further						

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NAME OF PROVIDER OR SUPPLIER		175537		B. WING		07/27/2015		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
HAYS ME	DICAL CENTER LTCU			V CANTERB KS 67601	URY DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 428	Continued From page	e 16		F 428				
	*Lovenox (blood thinning medication), 40 (mg) milligrams, by mouth, every day, initiated 7/1/15.							
	Lovenox (blood thinni box warning of spinal	apped in the tissues of which may result in	lack					
	*Risperdal (antipsychotic medication), 0.5 mg, by mouth, at bedtime, initiated 7/1/15.		g, by					
	According to www.fda.gov <a href="http://www.fda.gov">http://www.fda.gov</a> , Risperdal (antipsychotic medication) had a black box warning of increased mortality in elderly patients with dementia-related psychosis.		lack					
	The 7/6/15 physician's order further lacked an appropriate diagnosis for the use of an anti-psychotic medication.		ın					
	Review of the consultant pharmacist review, dated 7/6/15, of Resident #10's medications revealed no documentation of the lack of monitoring of medications with Black Box Warnings and did not identify the anti-psychotic medication required an appropriate diagnosis.							
	Resident #10, seated	M, observation revealed upright in his/her recliret, with the bedside tabler in front of him/her.	ner,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175537		B. WING	· · · · · · · · · · · · · · · · · · ·	07/	27/2015	
NAME OF PROVIDER OR SUPPLIER  HAYS MEDICAL CENTER LTCU			2220 S\	RESS, CITY, STA N CANTERB KS 67601	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 428	On 7/22/15 at 2:58 Pf verified the facility's constant and appropriate antipsychotic medical. The facility's consultare port to the director of the lack of monitoring Box Warnings and the diagnosis for the antip.  Resident #55's 5 Datassessment, dated 7/had intact cognition, rof 1 staff with most (A Living, and had an unfurther indicated their anticoagulant medical. The 7/15/15 care plar monitoring of the resident administer to the remedications. Further physician ordered medications. Further physician ordered medications. Further physician ordered medications ordered medications ordered medications. Further physician ordered medications ordered medications. Further physician ordered medications ordered medications. Further physician ordered medications.	M, Administrative Nurse onsultant pharmacist has keep of monitoring of the Box Warnings and the diagnosis for the cion.  In pharmacist failed to of nursing or the physic of medications with Black of an appropriate osychotic medication.  Ay (MDS) Minimum Data 11/15, indicated the resequired limited assistant LDLs) Activities of Daily isteady balance. The Mesident received tions.  In lacked direction to standent for adverse lated with the administrated with the administrated with the following review revealed the edications had (BBW) Burning medication), 15 (minum of sleep, initiated of A) Food and Drug	e  ian, ack  a Set sident nce  DS  ff for ation  staff lack	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175537		B. WING		07/2	27/2015
	OVIDER OR SUPPLIER DICAL CENTER LTCU	ı	2220 S	RESS, CITY, STA' W CANTERB KS 67601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTURE CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	According to the FDA a black box warning v potential for severe livallergic reactions (swe	, MedWatch, dated 1/1 was identified for the wer injury and a potentia elling of the face, moutl	3/11, al for n and				
	throat, difficulty breathing, itching or rash) will be added to the label of all prescription drug products that contain acetaminophenAdvise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day) = 4000 milligrams.  Review of the consultant pharmacist review,						
		ident #55's medications ntation of the lack of					
		M, observation revealed upright in his/her bed, pendently.	d				
	On 7/22/15 at 2:58 PM, Administrative Nurse A verified the facility's consultant pharmacist had not addressed the lack of monitoring of medications with Black Box Warnings.						
	report to the director	nt pharmacist failed to of nursing or the physic of medications with Blasident #55.					
F 441 SS=F	483.65 INFECTION O SPREAD, LINENS	CONTROL, PREVENT		F 441			
	_	blish and maintain an gram designed to provion fortable environment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175537		B. WING		07/2	7/2015	
NAME OF PR			STREET ADDR	ET ADDRESS, CITY, STATE, ZIP CODE				
HAYS MEDICAL CENTER LTCU				/ CANTERB S 67601	URY DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From page 19 to help prevent the development and			F 441				
	transmission of disease and infection.							
	Program under which (1) Investigates, contrin the facility; (2) Decides what program and the facility; (2) Decides what program and the facility; (2) Maintains a record actions related to infect (b) Preventing Spread (1) When the Infection determines that a resiprevent the spread of isolate the resident. (2) The facility must program direct contact will direct contact will train (3) The facility must resident.	blish an Infection Contrit - it - rols, and prevents infections, and prevents infections and individual resident; at of incidents and corrections.  If of Infection and Control Program ident needs isolation to infection, the facility metabolish ero infected skin lesions the residents or their footsmit the disease. The resident contact for valued by accepted	on, and ctive					
	(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.		of					
	The facility had a cen- sample included 4 res observation, record re- facility failed to provid	not met as evidenced be sus of 4 residents. The sidents. Based on eview, and interview the le a sanitary environme elopment and transmiss	ent to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		175537		B. WING		07/2	27/2015	
NAME OF PROVIDER OR SUPPLIER HAYS MEDICAL CENTER LTCU			2220 SV	RESS, CITY, STA V CANTERB (S 67601	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	a resident's bathroomequipment for the 4 refacility.  Findings included:  On 7/21/15 at 8:20 interior of the microwastation revealed splat from food products. Fapproximately 1/5 of remained clear of foodon on 7/22/15 at 1:40 PI Housekeeping Staff Eand he/she put on gloresident's bathroom. carried an uncovered bucket, and shower challway to the soiled opened the door with Housekeeping Staff Eroom and placed a bucleaner in it, on the bathousekeeping Staff Ecloth head to clean the removed the brush frobowl, placed the brush frobowl, placed the brush	on, by improper cleaning and associated nursing and associated nurse are also as a second and associated are also as a second as a	cles caled, d, 's n the eer, ne #56's th a ol	F 441				
	stated the facility staff equipment, to the soil point the equipment v be thoroughly cleaned stated staff used the s	M Housekeeping Staff If f carried the contaminated utility room, from the vent to central sterilizated. Housekeeping Staff I same toilet bowl brush to changed the soiled brush	ted at ion to B from					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175537			27/2015		
NAME OF PROVIDER OR SUPPLIER  HAYS MEDICAL CENTER LTCU				RESS, CITY, STA		•	
НАУ				KS 67601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	acknowledged carryin the hallway, and the u brush, placed in the b disinfectant and carrie	e 21 days. Housekeeping St ng the soiled equipment use of the same toilet be ucket with the bottles o ed from room to room, contamination to other	t in owl	F 441			
	On 7/22/15 at 3:34 PM, Housekeeping Staff C verified the increased risk of contaminating other areas and/or equipment the residents may come in contact with, by carrying contaminated equipment down the hallway. Housekeeping Staff C verified the use of the same toilet bowl brush in the bucket with the soiled bottles of disinfectant, carried from room to room, created an infection control problem.						
	occasionally used the	M, Nurse D stated staff microwave to warm for ight in by family membe	od				
	On 7/22/15 at 4:35 PM, Nurse A verified the staff did not clean the microwave as instructed and the microwave should be free of spatter.						
	procedure, instructed from the top down, sta- ceiling, and to clean t did not address trans	's Restroom Cleaning staff to clean the bathr arting with the vents an he toilet last. The proce portation of contaminat of the toilet bowl brush	d edure ed				
	The facility failed to p	rovide a sanitary					

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		175537		B. WING		07/27	7/2015	
NAME OF PR	AME OF PROVIDER OR SUPPLIER STREE		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
				CANTERB S 67601	SURY DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 441	Continued From page	e 22		F 441				
	environment to help prevent the development and transmission of disease and infection, by improper cleaning of the microwave, and resident bathrooms.							
F 520 SS=F		483.75(o)(1) QAA		F 520				
	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.							
	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.		nent of					
	A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.		to the					
	Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.		•					
	The facility had a cen sample included 4 res and record review, the (QAA) quality assess committee consisting	not met as evidenced because of 4 residents. The sidents. Based on intermeter facility failed to maint ment and assurance of the director of nursing designated by the facil	view ain a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
	175537			B. WING	<del> </del>	07/2	7/2015	
				RESS, CITY, STA	•	•		
HAYS MEDICAL CENTER LTCU				V CANTERB KS 67601	URY DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 520	. •			F 520				
	and at least 3 other m	nembers of the facility's	staff.					
	the following months attend the meetings. December 2014, Feb Review of the QAA coattendance revealed to	ealed the committee me and the physician did n (September 2014, ruary 2015, May 2015) ommittee meeting the physician did not at rd and 4th quarters of 2	ot tend					
	On 7/22/45 at 4:25 DI	M. Nurse A verified the						
		M, Nurse A verified the nd the QAA meetings o	n the					
		ne facility did not provid for the QAA program o						
		nsure the quality urance program maintai quired members of the	ined					